		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035527

Facility Name: Park Lawn Home

Address: 12615 S. Kostner (Number) Alsip (City) 60803 (Zip Code)

County: Cook

Telephone Number: (708) 385-1982 **Fax #** (708) 385-8145

IDPA ID Number: 36-2806708-002

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Janice Leise **Telephone Number:** (708) 425-3344

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7-1-02 to 6-30-03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) James R. Weise
(Title) Executive Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,935			4,935	13
14	TOTALS	4,935			4,935	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.14%

D. How many bed-hold days during this year were paid by Public Aid?
540 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6-30-03 Fiscal Year: 6-30-03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	3,004	467	960	4,431		4,431		4,431			1
2	Food Purchase		30,387		30,387		30,387		30,387			2
3	Housekeeping		2,218		2,218		2,218		2,218			3
4	Laundry		778		778		778		778			4
5	Heat and Other Utilities			1,474	1,474		1,474	10,180	11,654			5
6	Maintenance	20,371	3,175	2,022	25,568		25,568	14,840	40,408			6
7	Other (specify):*		712		712		712		712			7
8	**TOTAL General Services**	23,375	37,737	4,456	65,568		65,568	25,020	90,588			8
	B. Health Care and Programs											
9	Medical Director			2,250	2,250		2,250		2,250			9
10	Nursing and Medical Records	4,992	5,445	1,397	11,834		11,834		11,834			10
10a	Therapy			900	900		900		900			10a
11	Activities		1,077		1,077		1,077		1,077			11
12	Social Services	684		1,461	2,145		2,145		2,145			12
13	Nurse Aide Training											13
14	Program Transportation	6,183	4,002	1,845	12,030		12,030		12,030			14
15	Other (specify):* QMRP, Hab staff, Psy	272,143			272,143		272,143		272,143			15
16	**TOTAL Health Care and Programs**	284,002	10,524	7,853	302,379		302,379		302,379			16
	C. General Administration											
17	Administrative	44,467			44,467		44,467	17,166	61,633			17
18	Directors Fees											18
19	Professional Services			3,536	3,536		3,536		3,536			19
20	Dues, Fees, Subscriptions & Promotions			3,092	3,092		3,092	(60)	3,032			20
21	Clerical & General Office Expenses	61,476	11,006		72,482		72,482		72,482			21
22	Employee Benefits & Payroll Taxes			69,014	69,014		69,014	(641)	68,373			22
23	Inservice Training & Education											23
24	Travel and Seminar			892	892		892		892			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			985	985		985	8,979	9,964			26
27	Other (specify):* Trainer	3,779			3,779		3,779		3,779			27
28	**TOTAL General Administration**	109,722	11,006	77,519	198,247		198,247	25,444	223,691			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	417,099	59,267	89,828	566,194		566,194	50,464	616,658			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Lawn Home #0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			736	736		736	37,601	38,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,908	3,908		3,908	56,545	60,453			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			13,413	13,413		13,413		13,413			34
35	Rent-Equipment & Vehicles			18,080	18,080		18,080		18,080			35
36	Other (specify):* **Loss on Disposition**							2,175	2,175			36
37	**TOTAL Ownership**			36,137	36,137		36,137	96,321	132,458			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,484	33,484		33,484		33,484			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			33,484	33,484		33,484		33,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	417,099	59,267	159,449	635,815		635,815	146,785	782,600			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(641)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(60)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (701)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	147,486	5A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 147,486		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 146,785		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park Lawn Home

ID# 0035527

Report Period Beginning: 7-1-02

Ending: 6-30-03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Related Party Utilities	$ 10,180	5	1
2	Allowable Related Party Maintenance	14,840	6	2
3	Allowable Administrative	17,166	17	3
4	Allowable Related Party Insurance	8,979	26	4
5	Allowable Related Party Depreciation PLH	37,601	30	5
6	Allowable Related Party Interest PLH	56,395	32	6
7	Allowable Related Party Interest PLA	150	32	7
8	Allowable Related Party Loss on Disposition PLH	2,175	36	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	147,486		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7-1-02 **Ending:** 6-30-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	10,180	0	0	0	0	0	0	0	0	0	0	10,180	5
6	Maintenance	14,840	0	0	0	0	0	0	0	0	0	0	14,840	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	25,020	0	0	0	0	0	0	0	0	0	0	25,020	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	17,166	0	0	0	0	0	0	0	0	0	0	17,166	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(60)	0	0	0	0	0	0	0	0	0	0	(60)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(641)	0	0	0	0	0	0	0	0	0	0	(641)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	8,979	0	0	0	0	0	0	0	0	0	0	8,979	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	25,444	0	0	0	0	0	0	0	0	0	0	25,444	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	50,464	0	0	0	0	0	0	0	0	0	0	50,464	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Park Lawn Home** **#** **0035527** **Report Period Beginning:** **7-1-02** **Ending:** **6-30-03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	37,601	0	0	0	0	0	0	0	0	0	0	37,601	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	56,545	0	0	0	0	0	0	0	0	0	0	56,545	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	2,175	0	0	0	0	0	0	0	0	0	0	2,175	36
37	**TOTAL Ownership**	96,321	0	0	0	0	0	0	0	0	0	0	96,321	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	146,785	0	0	0	0	0	0	0	0	0	0	146,785	45

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Park Lawn Assoc.	Oak Lawn	Support Org. of PL
				Park Lawn Home, Inc	Alsip	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Park Lawn Association, Inc. See explanation on page 5A and in notes		$	$	1
2	V								2
3	V								3
4	V				Park Lawn Home, Inc. See explanation on page 5A and in notes.				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Central Office - 10833 S. LaPorte Avenue occupies 1,717 square feet for administration				$	$		$	1
2		and account ing and bookkeeping. This is 6.96% of total square footage 24,693.								2
3										3
4		These costs are collected in a temporary cost center and distributed out to programs on the								4
5		basis of a predetermined, appropriate distribution.								5
6										6
7		Administrative salaries are distributed as follows:								7
8		1. Executive Director - % of budget								8
9		2. Acct/Bkkp - % of budget								9
10		3. P/R Personnel - % of staff								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Hinsdale Bank			2002 Mercury Sable	$394.71	1-1-03	$ 20,662	$ 18,842	1-1-08	5.5000	$ 547	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$394.71		$ 20,662	$ 18,842			$ 547	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,662	$ 18,842			$ 547	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998		8
	1999		9
	2000		10
	2001		11
	2002		12

Exempt

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035527

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200.

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Exempt	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,524 B. General Construction Type: Exterior Concrete Frame Aluminum gutter dow Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Living Facility	77,381	1988	$ 77,042	1
2					2
3	TOTALS	77,381		$ 77,042	3

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15			1,991	$ 676,975	$ 27,079	25	$ 27,079	$	$ 312,047	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1995	18,306	732	25	732		5,919	9
10	Door East Side			2001	950	63	15	63		126	10
11	Bathroom Floor Tile			2001	625	42	15	42		108	11
12	Vinyl Flooring			2002	15,657	130	10	130		260	12
13	Storm Sewer			2002	3,780	32	10	32		64	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 716,293	$ 28,078		$ 28,078	$	$ 318,524	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 69,889	$ 9,017	$ 9,017	$	5/10	$ 46,245	71
72	Current Year Purchases	12,399	656	656		5/7	656	72
73	Fully Depreciated Assets							73
74	Disposal of Equipment	(6,215)					(4,040)	74
75	TOTALS	$ 76,073	$ 9,673	$ 9,673	$		$ 42,861	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See attached listing Page 24			$ 410,418	$ 586	$ 586	$	5	$ 331,088	76
77										77
78										78
79										79
80	TOTALS			$ 410,418	$ 586	$ 586	$		$ 331,088	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,279,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,337	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,337	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 692,473	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7-1-02
Ending 6-30-03

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2004	$ 22,698
13.	6/30/2005	$ 22,698
14.	6/30/2006	$ 22,698

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 1,579 Description: Pagers 194, Bottled Water Rental 106, Pace 707, Copier 572
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached listing		$ 29.33	$ 352	17
18					18
19					19
20					20
21	TOTAL		$ 29.33	$ 352	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 90 OJT

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Not Applicable	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7-1-02 **Ending:** 6-30-03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6-30-03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 459,053	1
2	Cash-Patient Deposits		28,934	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		1,848	5
6	Prepaid Insurance		9,080	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		911,168	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 1,410,083	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		450,009	16
17	Accumulated Depreciation (book methods)		(326,033)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 123,976	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 1,534,059	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 439,279	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		28,934	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		249,778	30
31	Accrued Taxes Payable (excluding real estate taxes)		9,622	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc.		17,191	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 744,804	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Equipment & Lease Fees		784,353	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 784,353	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 1,529,157	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,902	$ 4,902	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,902	$ 1,534,059	48

***(See instructions.)**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,902	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,902	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,902	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 559,990	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 559,990	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	75,825	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 75,825	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 635,815	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	65,568	31
32	Health Care	302,379	32
33	General Administration	198,247	33
	B. Capital Expense		
34	Ownership	36,137	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	33,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 635,815	40
41	**Income before Income Taxes (line 30 minus line 40)****		41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	138	208	$ 4,992	$ 24.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	27	27	684	25.33	11
12	Dietician					12
13	Food Service Supervisor	163	208	3,004	14.44	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,253	1,681	20,371	12.12	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,285	1,500	44,467	29.64	20
21	Assistant Administrator					21
22	Other Administrative	1,438	1,753	30,986	17.68	22
23	Office Manager	1,353	1,967	30,490	15.50	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,664	1,712	30,657	17.91	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,762	25,319	240,525	9.50	30
31	Medical Records					31
32	Other Health Ca Psych.	15	15	961	64.07	32
33	Other(specify) Trainer, Drivers	738	977	9,962	10.20	33
34	TOTAL (lines 1 - 33)	30,836	35,367	$ 417,099 *	$ 11.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	48	$ 960	1-3	35
36	Medical Director	18	2,250	9-3	36
37	Medical Records Consultant	5	175	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	18	900	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	58	1,461	12-3	45
46	Other(specify) Sec. Resc.	8	87	20-3	46
47	Psychiatrist	6	950	10-3	47
48	Audit, Payroll, Data Process, Web, Legal		3,536	19-3	48
49	TOTAL (lines 35 - 48)	161	$ 10,319		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 272	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8	$ 272		53

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Weise	Executive Dir.		$ 7,352
Eleanor Crumback	Administrator		29,530
Julia Grounds	Prog. Serv.		7,585
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 44,467

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Paychex	Payroll	$ 953
Cocalas, Westberg, Mommsen	Audit	1,036
Midwest Time Recorder	Data Processing	1,488
James Himmel	Legal	36
Core Com	Web Design	23
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 3,536

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,521
Unemployment Compensation Insurance	2,799
FICA Taxes	31,475
Employee Health Insurance	24,115
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Employer Match TSA	2,463
Man Ben $, not included in total	
TOTAL (agree to Schedule V, line 22, col.8)	$ 68,373

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	1,046
Health Care Worker Background Check	92
(Indicate # of checks performed 9)	
Membership Dues	1,173
Subscriptions & Texts	271
Public Relations	60
License Fee Other	50
Less: Public Relations Expense	(60)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,032

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached listing	892
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 892

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-02 Ending: 6-30-03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 & 7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **33,484**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **0** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A Personal use not permitted**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Cocalas, Westberg, Mommsen, Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

D. Vehicle Depreciation

	1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Program % Depre.	6 Straight Line Depr.	Program % Straight Line Dep.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation
78	Medical Appts.	91 Ford Aerostar	**	1991	$13,348.00	$0.00			$0.00			5	$13,348.00
79	Medical Appts.	93 Ford Econoline	**	1993	$20,602.00	$0.00			$0.00			5	$20,602.00
80	Medical Appts.	96 Mercury Sable	**	1996	$19,929.00	$0.00	3.22	$0.00	$0.00	$0.00		5	$19,929.00
81	Medical Appts.	95 Dodge Caravan	*	1996	$34,594.00	$0.00	3.22	$0.00	$0.00	$0.00		5	$34,594.00
82	Medical Appts.	93 Ford Club Wagon	**	1993	$21,272.00	$0.00			$0.00			5	$21,271.00
83	Medical Appts.	97 Ford Club Wagon	**	1997	$27,413.00	$0.00	3.22		$0.00			5	$27,413.00
84	Medical Appts.	94 Ford Econoline PA	*	1994	$35,416.00	$0.00			$0.00			5	$35,416.00
85	Medical Appts.	96 Dodge Caravan	*	1996	$34,594.00	$0.00	3.22	$0.00	$0.00	$0.00		5	$34,594.00
86	Medical Appts.	97 Dodge	*	1997	$34,995.00	$4,666.00	3.22	$0.00	$4,666.00	$0.00		5	$34,995.00
87	Medical Appts.	96 Ford Eldorado	*	1996	$51,286.00	$4,293.81	3.22	$0.00	$4,293.81	$0.00		5	$51,286.00
88	Medical Appts.	99 Dodge Max Van	*	1999	$19,094.00	$3,818.80	3.22	$122.97	$3,818.80	$122.97		5	$15,434.32
89	Medical Appts.	00 Dodge Maxi Van	*	2000	$19,977.00	$3,995.40	3.22	$128.65	$3,995.40	$128.65		5	$11,819.73
90	Medical Appts.	01 Light Duty Ford Eldorado	*	2002	$44,353.00	$5,913.73	3.22	$190.42	$5,913.73	$190.42		5	$5,913.73
91	Medical Appts.	02 Mini Van Chevy Venture	*	2002	$33,545.00	$4,472.67	3.22	$144.02	$4,472.67	$144.02		5	$4,472.67
					$410,418.00	$27,160.41		$586.06	$27,160.41	$586.06			$331,088.45

* Owned by Park Lawn School Depreciation	586.06
** Owned by Park Lawn Association Depreciation	0
	586.06

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign ane vehicle to any one location, costs are assigned on a percentage of use basis.

XII. C. Vehicle Rental

	1 Use	2 Make, Model & Year	3 Monthly Lease Pymt.	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
17	Medical Appts. & Activities	93 Ford Club Wagon	$86.00	0.0612	$5	$63.16
18	Medical Appts. & Activities	96 Mercury Sable	$166.00	0.0612	$10	$121.91
19	Medical Appts. & Activities	97 Ford Club Wagon	$228.00	0.0612	$14	$167.44
21	Totals		$480.00		$29	$352.51

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

Related Party Adjustment

Park Lawn Home

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2002/2003 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMEN	ORS	CILA	126TH ST. RESIDENTI/	115TH ST. RESIDENTIAL
Total Lease	369,929	60,812	107,935	11,194	0	14,594	31,546	143,848
LESS: Community Lease	37,708	7,341	13,857	3,400	0	3,079	1,579	8,452
Related Organization	332,221	53,471	94,078	7,794	0	11,515	29,967	135,396
Interest & Depreciation Related Organization	321,076	22,378	71,633	6,125	0	77,725	95,180	48,035
Adjustment	(11,145)	(31,093)	(22,445)	(1,669)	0	66,210	65,213	(87,361)
Adjust Related Organization	321,076	22,378	71,633	6,125	0	77,725	95,180	48,035
Community Lease	37,708	7,341	13,857	3,400	0	3,079	1,579	8,452
Grand Total Allowable Lease	358,784	29,719	85,490	9,525	0	80,804	96,759	56,487
Other Adjustments								
Management Benefits	(6,174)	(662)	(972)	(122)	0	(1,546)	(641)	(2,231)
Public Relations	(6,307)	(44)	(5,944)	(8)	0	(104)	(60)	(147)
In Kind	0	0	0	0	0	0	0	0

	PLA	PLH
Total Interest	95,131.00	56,395.00
Total Depreciation	159,432.00	37,601.00
	254,563.00	93,996.00
PLH	93,996.00	
	348,559.00	
Fundraising	-27,483.00	
	321,076.00	

PLA Depreciation	
Bldg. Depreciation	120,587.00
Equipment Depreciation	38,845.00
	159,432.00

Mortgage Interest	94,584.00
Vehicle Interest	547
	95,131.00

Explanation Notes:

Detail of Other Lines over $1,000 or multiple type of expeses on Page 3

Line 7 Column 2

Waste Removal	$348
Plant Security	$364
	$712

Line 15 Column 1

QMRP	$30,657
Psych	$961
Hab Aides	$240,525
	$272,143

Schedule V. Page 3 & 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	$10,180
Line 6 Column 7	Allowable Related Party Costs for Maintenance	$14,840
Line 17 Column 7	Allowable Related Party Costs for Administrative	$17,166
Line 26 Column 7	Allowable Related Party Costs for Insurance	$8,979
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	$37,601
Line 32 Column 7	Allowable Related Party Costs for Interest PLA	$150
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	$56,395
Line 36 Column 7	Allowable Related Party Costs for Loss on Disposal PLH	$2,175
	Total Related Party Costs	$147,486

Line 34 Column 4 Includes:

Office for Park Lawn School Program	$11,214
Equipment from Park Lawn Association	$2,199
	$13,413

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	$352
Portion of Rent not in HUD Payments Park Lawn School Costs	$12,764
Equipment Rental	$4,257
Pace Vehicle Rental	$707
	$18,080

Schedule VII. Part B Page 6

Park Lawn Association, Inc.

Depreciation of Vehicles		$0
Interest of Vehicles 547.46 X 3%	$16	
PLS Interest 8369.32 X .016%	$134	
		$150
Total Park Lawn Association Costs		$150

Park Lawn Homes, Inc.

Utilities	$10,180	
Maintenance	$14,840	
Administration	$17,166	
Taxes/Insurance	$8,979	
Interest	$56,395	
Loss on Disposition of Property	$2,175	
Depreciation Bldg. & Equipment	$37,601	*
Total Park Lawn Homes Costs	$147,336	

* Building Depreciation does not include $3,000 in Certification Fees

Total Related Party Adjustment on Page 5A Line 49 $147,336

Schedule IX. Page 9
Line 15 $16 is the allowable portion of program interest, see page 5 line 35

Schedule XI. Part D. Page 13
Line 46 Column 5 Includes only program portion of depreciation cost on vehicles. Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

Schedule XII. Part C Page 14
Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis. These vehicle costs are only the program portion and are only for medical appointments and activities. A detail schedule of proration is attached on page 25.

Schedule XIII. Part B Page 15
Line 5 Column 4 Wages are included on page 20 line 33.

Schedule XIX. G. Page 21

Seminar Expense

American Red Cross	$309
ARC of Illinois	$382
Health Ed	$65
SW Community Services	$25
Skill Path	$21
Fred Pryor	$15
Health Prof. Instit	$67
Dollinger Co	$8
	$892

Schedule XX. Page 23

Question 12 Allocated based on hours worked per department.

Question 15 No Employee meals are served.